

Theodore Multipurpose Health Service maternity service



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Theodore Multipurpose Health Service

28. Facility

28.1 Facility overview

Theodore MPHS opened its doors in 1961; it was destroyed by fire and rebuilt in 1976.⁹⁸ In 2001, the hospital established itself as the Theodore Multipurpose Health Service (MPHS), in partnership with the Theodore Council on the Ageing Inc. The MPHS falls within the Banana Shire of Central Queensland, one of the outermost towns in the CQHHS catchment area. It is 84 kilometres south west of Biloela, 229 kilometres south west of Rockhampton and, 214 kilometres south west of Gladstone. It provides services to a number of local townships and surrounding areas including, Cracow, Camboon, Glenmoral, Isla and Lonesome Creek (approximately 1,200 people).

The MPHS has 10 overnight patient beds; five of these beds are allocated as aged care residential places, one of which is used for respite and palliative care or to support aged care patients awaiting a placement. The emergency department operates 24-hours per day. The Theodore Medical Clinic is co-located with the MPHS and works in partnership to provide a weekly antenatal clinic. The MPHS also offers postnatal services.

The maternity and neonatal services at Theodore MPHS have been assessed by CQHHS as a CSCF Level 1 service.⁹⁹ This is one of several Level 1 maternity services across CQHHS. According to the CSCF modules for maternity and neonatal care, a Level 1 service is expected to provide:

- no planned birthing services and appropriate training in imminent birth, basic life support and neonatal resuscitation
- antenatal and postnatal care provided by general practitioners or registered midwives—if there are maternal or fetal risk factors then antenatal care should be provided in partnership with a higher level maternity service
- care of healthy neonates with a gestational age of 37 weeks or greater—the care predominantly occurs in home or community settings
- appropriate access to a range of education and support services (located on-site or off-site) including, smoking cessation support, antenatal and postnatal psychosocial review, healthy hearing screening, parenting, bonding, feeding and lactation education.¹⁰⁰

⁹⁸ <https://hoteltheodore.com.au/town-of-theodore/>

⁹⁹ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

¹⁰⁰ CSCF, Maternity Services, Module Overview, version 3.2 and CSCF, Neonatal Services, Module Overview, version 3.2.

28.2 Maintenance of Level 1 maternity service

Theodore was flooded in December 2010 and January 2011 causing considerable damage across the town including to the Theodore MPHS. The Theodore MPHS had to be repaired and parts of it rebuilt before full services could be restored, this included the operating theatre and birth suite. From 2011 onwards, the Theodore MPHS was unable to accommodate planned birthing services, operating as a Level 1 maternity service due the lack of appropriate facilities. Previously it was a Level 2 maternity service, the primary difference between the two capability levels being the provision of planned birthing services.

In October 2016, the flood repair work, including the availability of a birthing room, was completed. The community considered that access to the birthing room would result in planned birthing services being reinstated; however, in June 2018, the Chief Executive of CQHHS held a community meeting where it was announced that, due to safety concerns, the MPHS would remain a Level 1 maternity service. Expectant mothers would need to travel to Biloela, Gladstone or Rockhampton Hospitals to give birth, dependent on their risk status.

The Theodore community was dissatisfied with the decision, believing that it transfers the risk of birthing onto pregnant women, and lobbied the Queensland Government and CQHHS for a restoration of their Level 2 maternity service. There are no current plans for the reinstatement of planned birthing services at the Theodore MPHS but this will likely be reviewed in line with the Minister for Health and Minister for Ambulance Service's announcement on 19 June 2019 in relation to the Rural Maternity Taskforce, which requires each HHS to review its rural and remote maternity services over the next two years to ascertain whether services can be restored.

29. Maternity service review

Between August 2017 and January 2018, the CQHHS undertook an internal review of the Theodore maternity service. The review was undertaken as part of CQHHS' commitment to reviewing all of its maternity services to establish the baseline of the safety and quality of the services across the catchment facilities.

The review concluded that there was an overall positive culture within the service and across the Theodore MPHS. However, the maternity service had been developed in accordance with traditional medically-led principles and did not represent a contemporary maternity service. Also, the reduced activity within the service was resulting in significant gaps in the recency of practice for clinical staff. Specifically, the Nursing and Midwifery Board of Australia (the Board) outlines registration requirements for midwives, including that on initial registration and at each renewal a midwife must be able to satisfy the Board that they have undertaken a minimum of 450 hours of practice within the last five years.¹⁰¹ This practice requirement is difficult to achieve if there are insufficient births in rural and remote services to enable midwives to maintain their recency of practice. The birthing numbers in Theodore between

¹⁰¹ Nursing and Midwifery Board of Australia, *Registration Standard: Recency of Practice*, 1 June 2016.

2005 and 2011 (Table 3 below) would unlikely have been sufficient to enable midwives to maintain their registration.

Table 3 Theodore MPHS births 2005 to 2011¹⁰²

Year	No. of births
2005/2006	0
2006/2007	0
2007/2008	2
2008/2009	4
2009/2010	26
2010/2011	17

The review identified that the maternity service needed to be improved through the provision of contemporary, evidence-based practices that were in line with the service's capability level. One of the key areas of focus was on recognising deterioration and ensuring appropriate escalation to higher level facilities as required. It was also identified that communications with the community needed to be clear and consistent regarding the scope of maternity services available at the facility. The discussions with the community about the capability level of the service are discussed in section 31.4 below. The complete suite of recommendations were presented to staff at Theodore MPHS on 8 October 2018.

30. Complaints to the office

While this chapter draws primarily from the issues identified through the CQHHS internal review and by staff when analysing the investigative material in relation to the Theodore MPHS, the office received one enquiry about the maternity service at Theodore MPHS between June 2015 and December 2018.¹⁰³ This enquiry was not taken further as it related to matters outside of the office's jurisdiction.

31. Issues affecting maternity services at Theodore Multipurpose Health Service

The following sections provide a detailed analysis of the issues investigated by the office. The sections include a recommendation for change so that quality and safety systems supporting the maternity service can continue to be implemented and embedded at Theodore MPHS.

¹⁰² Figures provided by CQHHS during the adverse comment phase.

¹⁰³ The total number of complaints does not include complaints which are still pending an outcome.

31.1 Clinical governance

The CQHHS internal review, outlined above, made 16 recommendations for change to the Theodore MPHS maternity service. The recommendations focused on the need to redesign a contemporary and collaborative Level 1 maternity service that offers safe and high quality antenatal and postnatal care. The announcement of the continuation of the Level 1 maternity service in Theodore MPHS overshadowed other work in recent months meaning that implementation of the review recommendations has not been commenced. There is important work that needs to be completed through those recommendations to ensure that the maternity service meets its Level 1 capability requirements, including by securing clear referral pathways to higher level services and the development of the necessary models of antenatal and postnatal care (these are discussed further in sections 31.2 and 31.3 below).

Additionally, as part of the service redesign, the Theodore MPHS needs to develop sufficient safety and quality governance processes, such as policies, procedures and community information brochures, as a matter of priority. Clarity around the level of the service and its capability requirements also needs to be clearly articulated to the community so that they have an understanding of what the capability level entails, particularly as many of the services will be maintained e.g. antenatal clinics, telehealth with higher level services, and postnatal community visiting. This same messaging needs to be made clear by any medical practitioners who have previously provided shared care with the health service, as they need to be explicit about the limitations of the shared care in relation to the location of birth.

The action plan supporting the implementation of the recommendations categorises the redesign of the service as a high risk and was awaiting the recruitment of an Assistant Director of Nursing for Gladstone and Banana before the work could commence. Based on the length of time since the review recommendations were finalised, priority must be given to commencing implementation. As this will be a considerable body of work for a small health service, it will be important that it is introduced at a steady pace, with safety, and all that encompasses, as the main consideration. While the Theodore MPHS has the review recommendations to drive it to become a quality Level 1 maternity service, I am of the view that a recommendation is necessary to ensure the timely implementation of the recommendations.

Recommendation 7

I recommend that:

7. CQHHS provides six monthly status reports to the office on the implementation of the internal review recommendations until all recommendations are implemented and their fully implemented status is confirmed by the office.

31.2 Risk and escalation

As a Level 1 service it is important that staff properly categorise a woman's maternal risk status during the antenatal period, and where issues are identified, that there are established pathways in place for escalating care to a higher level facility such as Biloela, Gladstone or Rockhampton Hospitals. To date the office has not received any complaints suggesting that the Theodore MPHS needs to improve its risk categorisation and escalation and CQHHS has an established referral pathway for transferring between lower and higher level facilities. Accordingly, it will be important that these referral pathways continue to

be embedded and strengthened as the maternity service in Theodore is redesigned and becomes more settled.

To manage risk throughout the intrapartum period it would benefit the Theodore MPHS to build into its maternity redesign partnership and participation in some of the other CQHHS maternity services' antenatal clinics and case conferences. This will enable Theodore MPHS to discuss any high risk cases in appropriate forums, seeking advice and assistance from more senior and specialist clinicians throughout the CQHHS maternity network. These interactions also have an ancillary benefit of ensuring that the midwives at Theodore MPHS are aware of contemporary approaches to higher risk antenatal care and have increased exposure to more complex cases, which assists with identifying risk.

Given CQHHS has well established referral and communication pathways across its maternity services for managing and responding to risk, I am confident that the redesign of the Level 1 service for antenatal and postnatal care will appropriately capitalise on the experiences and resources across the catchment and will be addressed through the implementation of the review recommendations discussed above.

31.3 Models of care

The provision of contemporary antenatal and postnatal care is a key capability of a Level 1 maternity service, yet the care available at the Theodore MPHS does not appear to be meeting this requirement, leaving the women in the community with little or no care. In March 2019, during a community meeting between staff from the office and representatives from Theodore, community members commented that the antenatal and postnatal care provided via the Theodore MPHS was poor, with the perception being that postnatal care was completely absent because staff were not rostered on to provide such services and instead had to fit them around general nursing duties.

Rosters provided by CQHHS evidence that one staff member is rostered on for an antenatal clinical from 07:00 to 15:30 each Monday. This is confirmed by the BPF, which notes that the antenatal clinic is provided once a week in partnership with the general practice. There is no corresponding rostering for postnatal care, whether this is being provided in the hospital or via community visiting. This likely supports the community's view that this function is part of general nursing duties.

In relation to antenatal care, one clinic per week may be sufficient due to the lower numbers of birthing women being serviced by the Theodore MPHS, however, sufficient staffing hours also need to be made available for high risk telehealth appointments and ad hoc antenatal care. Antenatal care has one of the strongest correlations to various adverse outcomes. For example, Queensland Health identified that women with five or less antenatal appointments were found to be at 1.4 and 1.3 times the risk of a stillbirth or neonatal death, respectively, than women without the risk factor, based on data collected between 2007 and 2012.¹⁰⁴ Similarly, RANZCOG echoes the importance of antenatal care in detecting fetal abnormalities that may lead to perinatal deaths if they are not addressed.¹⁰⁵ By providing and

¹⁰⁴ https://www.health.qld.gov.au/data/assets/pdf_file/0032/355397/risk_chart.pdf

¹⁰⁵ https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report

facilitating high quality antenatal care within the Theodore MPHS this will likely result in more women accessing the service, and by extension attending more antenatal visits, which may contribute to better outcomes for mothers and babies.

The Senate Select Committee on Stillbirth Research and Education's report (the report), released in December 2018, cited telehealth as an important mechanism for ensuring women receive antenatal care within their community from a suitably qualified and consistent practitioner, whether that is a midwife, GP obstetrician or specialist obstetrician.¹⁰⁶ This model is already being used across CQHHS, as discussed above in section 26.3 in relation to the use of telehealth for antenatal clinics and care in Emerald, and could be replicated to support the provision of antenatal and postnatal care in Theodore. This is an opportunity for CQHHS to redesign the antenatal and postnatal service in concert with the community and based on the experiences of the other maternity services across its network. During the community meeting, staff from the office were advised that the community provided a clear message that they wanted contemporary and fulsome antenatal and postnatal care designed to suit their needs.

One of the main recommendations from the internal review was the redesign of the service to meet the requirements of a Level 1 service. I am confident that through the implementation of this recommendation that the Theodore MPHS will introduce a high quality antenatal and postnatal service to support the Theodore and wider-Banana community. The observations made in this section should assist with the redesign of this service.

31.4 Patient centred care

Standard 2 of the National Standards '*...aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services...this standard, together with the Clinical Governance Standard, underpins all other standards*'.¹⁰⁷ An expected outcome of this standard, when fully implemented, is that there will be systems in place to support consumers to partner with a health service in the evaluation of the healthcare system¹⁰⁸, this would extend to considerations around the provision of services. As part of the internal review conducted by CQHHS into the maternity service at Theodore MPHS there is no reference to the community being consulted, as there was with the other reviews, suggesting that no discussions were held with consumers about their maternity experiences.

Further, during the meeting between community representatives and staff from this office, community members advised that there was no consultation with the community about the decision to maintain a Level 1 maternity service. When the birthing suite was reopened during a ceremony in October 2016, the community thought that this signalled the return of planned birthing services. By June 2018, the community was advised that a Level 1 maternity service would be maintained, meaning that planned birthing would not be restored in Theodore. This was a major change for the community to digest and the feeling that their concerns had not been considered as part of the decision-making process compounded their dissatisfaction with the decision and the process by which the decision was reached.

¹⁰⁶ Ibid

¹⁰⁷ <https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/Partnering-with-Consumers.pdf>

¹⁰⁸ Ibid

When staff from my office asked the community whether they may have been more accepting of the decision had they been consulted they confirmed that while they still would not have been happy they would have been more accepting of the final decision. This appears to have been a missed opportunity for CQHHS to consult with the community about the social risks associated with maintaining the Level 1 service and considering those risks in reaching its final decision. As it stands the community is of the view that CQHHS has simply transferred the risk of birthing from the Theodore MPHS to the community and did so without consultation or appreciation of the community's views.

CQHHS has confirmed that the community was not consulted in relation to the decision to maintain the Level 1 maternity service because it was one made for safety reasons (including recency of practice concerns and an inability to provide sufficient medical staffing for a Level 2 service) and directed by the CQHHS Board. However, safety in the provision of maternity services encompasses a range of factors, some of which would be from the perspective of the community and should have been included as part of the decision making process, namely:

- cultural risk for Indigenous women birthing 'off country' and needing to receive culturally competent care to ensure that they engage antenatally¹⁰⁹
- emotional risk related to the distress and isolation many women report in having to travel away from home to birth in an unfamiliar environment with unknown clinicians¹¹⁰
- financial risk related to travelling to give birth¹¹¹ as for a small proportion of women it is recommended that they relocate to be near a birthing facility from 37 weeks gestation, with term being 37 to 42 weeks gestation¹¹², which can result in a woman having to be away from home for up to five or six weeks; longer if there are birthing complications.

The lack of consultation between CQHHS and consumers in relation to the maintenance of the Level 1 maternity service in Theodore represents a missed opportunity for CQHHS to partner with its community in evaluating the healthcare system. Going forward there is work to be done to rebuild the relationship between CQHHS and the Theodore community and a central tenet of this rebuilding will be ensuring that whenever possible CQHHS partners with the community to design and develop the maternity service. CQHHS has some excellent modelling to draw upon, with the success of the community engagement in Emerald, and should ensure that it trials an equally open and engaging relationship with the Theodore community. The Chief Executive also committed in June 2019 to meet with representatives from the community to open a dialogue about how to approach the provision of maternity services in the town.

32. Conclusion

While the Theodore MPHS does not offer planned birthing services it was appropriate for the office to include it within this report given that it was one of the five services chosen by CQHHS for the internal

¹⁰⁹ Barclay, L et al, *Reconceptualising risk: Perception of risk in rural and remote maternity service planning*, *Midwifery* 38, 2016.

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Labour-and-Birth>

review discussed in section 29 above. The review identified major gaps in the capability of the Level 1 maternity service, recommending a complete redesign to ensure that it meets the requirements for a contemporary Level 1 service. These gaps were echoed by representatives from the community when they met with staff from this office in March 2019, noting that there was no antenatal or postnatal care.

Given that the Theodore MPHS has been operating a Level 1 maternity service since the 2011 floods, it is concerning that it does not have the expected supporting infrastructure currently in place to support this level of capability. Specifically, CQHHS and the Theodore MPHS need to focus on implementing the review recommendations to ensure that they have:

- adequate policies and procedures
- information materials targeted towards the community outlining the types of maternity services that will be offered at the Theodore MPHS
- strong antenatal and postnatal care pathways that are both midwifery and medically led.

Additionally, CQHHS needs to implement systems that will support strong community partnering in the evaluation and redesign of the maternity service at Theodore MPHS. Opportunities were missed to engage with the community and hear their views on the continuation of the Level 1 maternity service, which has created friction between the health service and the community. Effort now needs to be expended by CQHHS to start to rebuild the relationship and trust with the community to ensure that it is meeting the needs of the community, the requirements of the National Standards, and its staff in implementing a reinvigorated Level 1 maternity service.

Based on CQHHS' response in other maternity services to implementing recommendations and securing a high quality service, I am confident that CQHHS and Theodore MPHS will undertake the work required to reach a reliable, safe and high quality Level 1 maternity service. However, given the difficulties between CQHHS and the community, the significant body of work to be completed, and delayed progress to date, I will maintain routine oversight of implementation of the review recommendations to ensure that they are actioned fulsomely and in a timely manner.